

Bupa Care Services NZ Limited - ParkHaven Hospital

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	ParkHaven Hospital
Services audited:	Residential disability services - Intellectual; Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Mental health services; Residential disability services - Physical; Residential disability services – Sensory
Dates of audit:	Start date: 10 May 2016 End date: 11 May 2016
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	78



Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Parkhaven Hospital is part of the Bupa group. The service is certified to provide hospital (medical and geriatric), mental health hospital, psychogeriatric and residential disability (intellectual, physical and sensory) level care for up to 84 residents. On the day of the audit, there were 78 residents.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board and Ministry of Health. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, relatives, staff and management.

A care home manager who is appropriately qualified and experienced, manages Parkhaven. Feedback from residents and relatives is positive about the care and services provided. An induction and in-service training programme is provided.

Improvements are required around dementia staff training, performance appraisals, provision of registered nursing cover, 'as required' medication prescribing, infection control surveillance, restraint monitoring and early warning signs and relapse prevention plans.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is celebrated. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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A clinical manager/registered nurse and a Bupa operations manager support the care home manager. The quality and risk management programme includes a service philosophy, goals and a quality planner. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. There are resident meetings and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. A comprehensive education and

training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to. Staffing is flexible to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Prior to entry to the service, residents are screened and approved. There is an admission package available prior to or on entry to the service that includes information on the services provided at Bupa Parkhaven. The registered nurses are responsible for each stage of service provision. The registered nurses assess and review residents' needs, outcomes and goals with the resident and/or family. Resident files included medical notes and notes of other visiting allied health professionals.

An occupational therapist usually oversees the activity team and coordinates the activity programme for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical and cognitive abilities and preferences for each consumer group. There are specific activities for younger people. Residents and families report satisfaction with the activities programme.

Medication policies reflect legislative requirements and guidelines. Staff responsible for the administration of medicines complete annual education and medication competencies. Medication charts have photo identification and allergy status noted.

All meals are prepared on site. Individual and special dietary needs are catered and alternative options are available for residents with dislikes. A dietitian has reviewed the menu.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are documented processes in place for the management of waste and hazardous substances and incidents are reported in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. The building has a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are spacious and personalised with access to shared ensuites or communal facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were 12 residents with restraint and 9 residents with an enabler. Restraint management processes are adhered.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Infection-control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	0	6	0	0	0
Criteria	0	118	0	6	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. There were interviews with all seven registered nurses (two mental health and psychogeriatric services; one who works in all areas; two hospital; one unit coordinator from the hospital and one unit coordinator from the psychogeriatric and mental health units) reflected their understanding of the key principles of the Code. Ten caregivers, (four mental health and psychogeriatric services and six hospital,) five activities staff, the clinical manager and the care home manager, also reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission as sighted in nine of nine resident files sampled (four hospital, two mental health and three psychogeriatric). Advance directives if known, were on the resident files. Resuscitation plans were sighted in the files and were signed appropriately. Copies of EPOA were on all files and activated as required.</p>

<p>informed choices and give informed consent.</p>		
<p>Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on advocacy services through the HDC office is included in the resident information pack provided to residents and family on admission. Pamphlets on advocacy services are available at the entrance to the facility and located around the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends, and community groups by encouraging their attendance at functions and events, and providing assistance to ensure they are able to participate in as much as they can safely and desire to do. This includes resident's visits to the local mall, visiting the library and attending community celebrations. Resident/family meetings are held regularly and there are two monthly family participation groups in the mental health unit.</p> <p>All residents, especially younger residents are provided with opportunities to engage in the community and younger residents are encouraged in these activities as they are able.</p>
<p>Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register where verbal and written complaints are documented. All complaints have noted investigation, timelines, corrective actions when required and resolutions. Complaints are linked to the quality and risk management programme.</p> <p>Four complaints lodged in 2015 around residents' cares were thoroughly investigated and were subsequently signed off by CMDHB. Because of the complaints received, corrective actions were established and implemented around manual handling, continence management, and short-term plans and have been embedded into practice.</p> <p>Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that provided to new residents and their family. This information is also available at reception. The clinical manager/registered nurse (RN) discusses aspects of the Code with residents and their family on admission.</p> <p>Discussions relating to the Code are held during the resident/family meetings. Seven residents (all from the hospital including, one younger person) and six relatives interviewed (one hospital level, three psychogeriatric level and two mental health level [interviewed by the consumer auditor]), report that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care and residential disability level care.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service ensures that the residents' rights to privacy and dignity are recognised and respected at all times. The residents' personal belongings decorate their rooms. Residents in shared rooms have curtains for privacy and the occupation of shared rooms has been consented to by families (no residents in shared rooms were capable to consent). Discussions of a private nature are held in the residents' rooms or other private areas. The caregivers interviewed reported that they knock on bedroom doors prior to entering and ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they encourage the residents' independence by encouraging them to be as active as possible. All of the residents interviewed confirmed that their privacy is being respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect. Any suspected instances of abuse or neglect are dealt with in a prompt manner by the management team.</p> <p>Three psychogeriatric resident files reviewed identified that cultural and/or spiritual values, individual preferences are identified.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. During this audit there were seven Māori residents living at the facility. Cultural needs were identified in care plans reviewed. Culturally appropriate meals including hangi and boil ups are frequently provided.</p> <p>Māori consultation is available through the documented iwi links and Māori staff who are employed by the service. Staff receive education on cultural awareness during their induction to the service and as a</p>

and cultural, values and beliefs.		regular in-service topic. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.
<p>Standard 1.1.5: Recognition Of Pacific Values And Beliefs</p> <p>Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Pacific residents are valued and fostered within the service. They value and encourage active participation and input of the family in the day-to-day care of the resident. During this audit, 26 residents (34% of residents) identified as Pacific living at the facility. There are also a significant number of staff who identify as Pacific and all Pacific languages are spoken by staff.</p> <p>Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All caregivers interviewed were aware of the importance of the relationships between the Pacific consumer, their family and their community in the delivery of care for Pacific residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. A cultural day celebrating different cultures represented at the facility is held monthly.</p> <p>All care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p> <p>Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with two healthcare assistants from the psychogeriatric and mental health unit could describe how they build a supportive relationship with each resident. Interviews with families from the psychogeriatric and mental health unit confirmed the staff assist to relieve anxiety.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day (link 1.2.8.1). A general practitioner (GP) visits the facility at least weekly, a nurse practitioner visits at least weekly, and an afterhours GP service is in place. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is deemed not stable. Residents in the mental health unit and psychogeriatric units are reviewed by the psychogeriatrician regularly. The psychogeriatrician visits the service monthly and the psychiatric district nurses (a shared role by two people) visit at least fortnightly.</p> <p>A physiotherapist works 22 hours per week and a dietitian is available as required. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent.</p> <p>The GP interviewed is satisfied with the level of care provided.</p> <p>In 2015, all quality goals were met. The weight management audit increased to above 95%, this remained above 95% in 2016 and medication incidents reduced by 10%. This continues to decrease in 2016 with .2 per thousand bed-day's (year to date) compared to a national average of 1.1 in the hospital and none recorded in the psychogeriatric unit.</p> <p>InterRAI has been implemented across the facility. A process was put in place alerting registered nurses of when assessments and reviews were due.</p> <p>There has been increased attendance at hospital resident and family meetings. This has been achieved by ensuring invitations are sent out with enough time for families to be able to attend.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy, alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in resident files. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Ten accident/incident forms reviewed identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes.</p> <p>An interpreter policy and contact details of available interpreters is available. Interpreter services are used where indicated. Currently staff and families provide interpreter services. The information pack is available in large print and is read to residents who require assistance.</p> <p>Residents and family are informed prior to entry, of the scope of services and any items they have to pay</p>

		<p>for that are not covered by the agreement.</p> <p>A newsletter is published to keep families informed of happenings at Parkhaven.</p> <p>There is a specific 'Introduction to the psychogeriatric unit' booklet providing information for family, friends and visitors to the facility included in the enquiry pack along with a new resident's handbook providing practical information for residents and their families.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Bupa Parkhaven is part of the Bupa group. The service is certified to provide hospital (medical and geriatric), mental health hospital, psychogeriatric and residential disability (intellectual, physical and sensory) level of care for up to 84 residents.</p> <p>On the day of the audit there were 78 residents living at the facility. Forty-four residents in two hospital wings included one resident on respite, five residents on a young person with disability (YPD) contract, four residents on a long term chronic conditions (LTCC) contract and one resident funded by ACC. There were twelve residents in the mental health (MH) unit and twenty-two residents in the psycho-geriatric (PG) unit, which included one resident on a LTCC contract. There were no residents at an intellectual or sensory disability level of care. Twenty-five residents were enrolled in the day care programme, which is run by the activities staff (not reviewed as part of this audit).</p> <p>There is an overall Bupa business plan and risk management plan. Parkhaven has identified specific and measurable quality goals for 2016 in their annual quality plan. Progress reports are reported quarterly on goal achievement.</p> <p>The care home manager (non-clinical) has been a Bupa manager for four years and has been managing Bupa Parkhaven for two years. A clinical manager/registered nurse (RN) and a Bupa operations manager support her. The clinical manager has ten years' experience as an RN and holds a postgraduate certificate in older people's health. He is presently working on his advanced nursing degree. He is supported by two unit coordinators/RNs.</p> <p>The manager and clinical manager have undertaken a minimum of eight hours of professional development over the past 12 months relating to the management of an aged care service.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an</p>	FA	<p>In the absence of the care home manager, the clinical manager is in charge, with support from the operations manager. In the absence of the clinical manager, the two unit coordinators, who are both registered nurses, are in charge.</p>

<p>efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A 2016 quality and risk management programme is in place. Interviews with the care home manager, clinical manager and staff reflect their understanding of the quality and risk management systems put into place.</p> <p>Policies and procedures, and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures are being updated to include reference to InterRAI for an aged care service. New policies or changes to policy are communicated to staff, evidenced in staff meeting minutes.</p> <p>Data collected (eg, falls, medication errors, pressure injuries, wounds, skin tears, challenging behaviours, complaints) are collated and analysed with results communicated to staff via meetings and on staff noticeboards. Quality initiatives have been implemented including (but not limited to) to reduce bruising, improve RN documentation in residents' progress notes, and utilise Bupa trained casual staff instead of bureau staff to cover staff shortages.</p> <p>Internal audits are completed as per the internal audit schedule. Any area of non-compliance includes the implementation of a corrective action plan with sign-off by the clinical manager and/or care home manager when implemented. Internal audit results and corrective actions are communicated to staff.</p> <p>The health and safety programme at Bupa Parkhaven includes a trained health and safety officer who is supported by the care home manager. Annual health and safety goals are in place with quarterly reporting to head office on progress being made. Staff undergo annual health and safety training. They are encouraged to enrol in the Bupa Bfit programme. The health and safety committee meets two-monthly. Contractors require induction into the facility and sign a health and safety form when this has been completed. The health and safety policy is currently under review by the Bupa head office to ensure that it complies with new legislative requirements.</p> <p>Falls prevention strategies include a comprehensive investigation of residents' falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. Other strategies include the use of sensor mats and low beds. Residents at risk of falling are monitored with greater frequency.</p>
<p>Standard 1.2.4: Adverse Event</p>	<p>FA</p>	<p>An accidents and incidents reporting policy is being implemented. Ten accident/incident forms were</p>

<p>Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>randomly selected for review. A registered nurse and the clinical manager investigate all clinical events. Accident/incident forms with a suspected injury to the head included two-hourly neurology observations.</p> <p>Adverse events are trended and analysed and are discussed with staff. Staff interviewed confirmed that they are kept well informed about accidents/incidents in a variety of ways (eg, meetings, toolbox talks, handovers, and noticeboards). There is evidence to support actions are undertaken to minimise the number of adverse events.</p> <p>Discussions with the care home manager and clinical manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. The DHB was notified following an influenza outbreak in July 2014. One case of campylobacter was notified to Public Health in January 2015.</p>
<p>Standard 1.2.5: Consumer Participation</p> <p>Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.</p>	FA	<p>The services Bupa policy consumer participation - mental health units - describes the ways in which residents can participate in the service. The eligibility criteria for this service requires that residents have dementia, which prohibits them from participating to a level involving input into planning and evaluation, and there are no terms of reference or employment of residents. An annual relative satisfaction survey is completed and there are regular relative meetings. Family/whānau members who have enduring power of attorney, on behalf of the client have input into the service through satisfaction surveys, regular family meetings and informal feedback.</p>
<p>Standard 1.2.6: Family/Whānau Participation</p> <p>Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.</p>	FA	<p>The services family/whānau and carer participation policy describes how the service receives feedback and input from family, such as surveys and evaluations. Family/whānau/carer input occurs at both formal and informal levels. With residents consent (although no current residents have the capacity to provide informed consent) or enduring power of attorney families/whānau/carer and/or significant others are asked to participate in the personal care planning process. There is a two monthly family participation meeting in the mental health unit, with management in attendance for residents and families to participate in service planning and evaluation.</p> <p>There is also verbal feedback to staff, satisfaction surveys, and the availability of the complaints process. Staff from the mental health unit were very aware of the importance of family/whānau involvement in resident's treatment and actively supports this. Family members from the mental health unit reported feeling included and valued and that feedback and ideas listened to and acted on. Family/whānau are not currently used in an advisory capacity however, clear terms of reference have been developed.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are human resource management policies in place that includes the recruitment and staff selection process. There are relevant checks completed to validate the individual's qualifications, experience and veracity. Copies of current practising certificates are retained for all health professionals. Ten staff files were reviewed (one clinical manager, three registered nurses, three caregivers, two kitchen/laundry staff, one activities assistant). Reference checks are completed before employment is offered.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme is being implemented which is supplemented with impromptu toolbox talks during staff handovers and staff regularly completing competency questionnaires. Caregivers are encouraged to complete an aged care education programme. Three staff working in the garden wing (mental health and psychogeriatric) have been employed for over one year and have not completed their dementia standards.</p> <p>Bupa has implemented a PDRP programme approved by the NZ Nursing Council. Three RN staff have completed their PDRP and one RN is working on hers. The nursing staff attend external training provided by the organisation and the DHB.</p> <p>The clinical manager reports that there are a range of in-services provided annually in relation to residential disability services including (but not limited to) suicide prevention, sexuality and intimacy, cultural competency (one YPD resident identifies as Māori), and advanced nursing practice.</p> <p>The care home manager reports that staff annual performance appraisals are behind schedule. This was confirmed in a selection of staff files reviewed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Low</p>	<p>The staffing policy describes staff rationale and skill mix. The clinical manager and two unit coordinators (one hospital wing and one psychogeriatric (PG) and mental health (MH) garden wing) are registered nurses who work Monday through Friday.</p> <p>One registered nurse is rostered to work in the garden wing 24/7, which includes MH and PG residents. Hospital level nurse staffing alternates between an enrolled nurse and a registered nurse on the night and weekend shifts. Adequate numbers of caregivers are rostered. Activities staff are rostered for the care home and the day care programme.</p> <p>Extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>are protected from unauthorised access. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant carer. Residents' files demonstrate service integration. Medication charts are in a separate folder.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There are pre-entry and admission procedures in place. Access to the mental health unit, which is a regional unit, is via the Counties Manukau Mental Health of Older Persons service. When a resident is referred via this service or a resident is referred to the psychogeriatric unit, the unit coordinator completes a pre-admission assessment prior to admission, to ensure stability for the service. Residents are admitted to the mental health unit under a compulsory treatment order (CTO). Needs assessors are involved in the pre-entry screening for hospital residents.</p> <p>The service has a comprehensive information booklet for residents/families/whānau at entry.</p> <p>Nine admission agreements reviewed, aligned with a) - k) of the ARC contract. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p> <p>Written information on the service philosophy and practices particular to the psychogeriatric and mental health units, including minimisation of restraint, behaviour management and complaint policy are included in the information pack.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>In relation to mental health services provided: Residents in the mental health unit are all assessed as requiring a secure mental health unit providing 24-hour care. Residents are not usually discharged home but do move to lower levels of care if reassessed. If a resident transfers to unit, detailed information is provided. Usually this occurs within the facility and the entire resident file moves with the resident.</p> <p>For all residents: The service has transfer and discharge procedures in place. Inter-facility transfers and transfers to hospital are planned and coordinated, in consultation with the family/whānau as appropriate. All relevant information is documented and communicated to the receiving health provider or service. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines</p>	<p>PA Low</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff (RNs only) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Standing orders are used. No residents</p>

<p>in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>were self-medicating.</p> <p>The medication charts reviewed identified that the GP/NP had seen and reviewed the resident three monthly. Not all charts had PRN medication use detailed. Anti-psychotic management plans are used for residents using anti-psychotic medications when medications are commenced, discontinued or changed. The psychiatrist reviews the management plans at least two monthly or earlier if required.</p> <p>Eighteen medication charts sampled (ten hospital, four psychogeriatric and four mental health) identified that the GP or psychiatrist had reviewed the medication chart three monthly. Medication charts demonstrated appropriate prescribing except for some 'as required' medications, documentation of allergies, photographic identification and at least three monthly reviews by a GP/NP. Administration records sampled correspond with prescribed medications.</p> <p>Temperatures of medication fridges have been documented as per policy. There were no expired medications in use.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Parkhaven are prepared and cooked on site. Three cooks cover the week. There is a four weekly seasonal menu, which had been reviewed by a dietitian. Meals are plated in the kitchen and delivered in scan boxes, to each unit's dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free, diabetic desserts are provided. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks in the psychogeriatric unit and hospital. Supplements are provided to residents with identified weight loss issues. One-to-one feedback, plate waste audits, resident/relative meetings and surveys allow the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded on each meal following cooking and on loading into scan boxes. The chemical supplier checks the dishwasher regularly.</p> <p>There is evidence that there are additional nutritious snacks available over 24 hours in the mental health and psychogeriatric units.</p> <p>All food service staff have completed training in food safety and hygiene and chemical safety.</p>
<p>Standard 1.3.2: Declining</p>	<p>FA</p>	<p>There is an admission information policy. The reasons for declining entry would be if the service were unable to provide the specialised care required or there are no beds available. Management</p>

<p>Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>communicate directly with the referring agencies and family/whānau as appropriate, if entry is declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Cultural assessments are completed on admission for all residents. Cultural assessments were completed in all nine resident files sampled. The care plans document the resident's cultural needs, values and spirituality and supports (including support persons) available to ensure the resident's needs are met.</p> <p>The RN completes an initial assessment on admission, including risk assessment tools. Resident needs and supports are identified through InterRAI triggers and the ongoing assessment process in consultation with significant others. InterRAI assessments have been undertaken on all residents and are used for six monthly reviews. The diversional therapist (DT) completes an activity assessment that identifies individual activities and preferences. A 'My Day, My Way' plan is completed which documents the resident's cultural needs, values and spirituality and supports (including support persons) available to ensure the resident's needs are met.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>Resident care plans reviewed were resident focused. All identified support needs were included in the care plans for nine of nine residents files sampled. Care plans sampled evidenced resident (as appropriate)/family/whānau involvement in the care plan process. Relatives interviewed confirmed they are involved in the care planning process. Resident files demonstrate service integration.</p> <p>Three of three psychogeriatric resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. Behaviour charts and behaviour monitoring charts were in use, as appropriate, for escalation in behaviours.</p> <p>One of two mental health resident files reviewed had a documented plan that identified early warning signs and relapse-prevention strategies. Both files documented that families are involved in care planning, and care and support.</p> <p>Short-term care plans are used for short-term needs. Short-term care plans sighted in resident files were for pressure injury, pain, wound and skin condition.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications were documented in the resident file sampled in the family/whānau contact form.</p> <p>The mental health and psychogeriatric units have designated psychiatric nurses. A psychiatrist also visits the mental health unit and psychogeriatric service monthly for scheduled reviews and more often if required. Mental health resident files reviewed document that the care and support provided is consistent with needs and fully communicated to family. The need for a secure unit has been documented by referral agencies. The mental health residents whose files were reviewed receive appropriate care.</p> <p>There is specialist input into resident's well-being in the psychogeriatric unit. The care team and activities staff could describe strategies for the provisions of a low stimulus environment.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds, skin tears and pressure areas (three sacral). There is evidence of GP involvement and photos for chronic wounds/pressure areas. Chronic wounds have been linked to the long-term care plans. There was evidence of wound nurse specialist, dietitian and NP involvement in the management of wounds.</p> <p>Residents are routinely weighed (monthly). Nutritional requirements and assessments are completed on admission, identifying resident nutritional status.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Three registered nurses and one enrolled nurse were able to describe access for wound and continence specialist input as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service has a position for an occupational therapist who oversees the recreation programme for 20 hours per week. The position was recently vacated and is being actively recruited for. The remaining activities team consists of a full time activities coordinator, three full time activities assistants and an activities assistant who works Monday to Friday. This team also supports the day care residents in a combined programme with hospital residents. The activity team provides individual and group activities in the hospital, psychogeriatric and mental health units. The programmes in the mental health and psychogeriatric units are flexible, according to residents needs and include a significant number of 1:1 activities. These units also have documented programmes provided for staff to implement when the activities staff are not present. Activities staff have scheduled times to provide 1:1 care for residents who are not able to or do not wish to engage in the group activities. Activities in each unit are varied and interesting and meet the needs of residents. There are regular outings/drives, inter-home visits for the</p>

		<p>choir and involvement in community events.</p> <p>Specific activities including opportunities to attend community groups and activities are specifically provided for the group of younger people.</p> <p>Care staff were observed at various times throughout the day diverting residents from behaviours in the dementia, mental health and psychogeriatric units. The individual activities observed were appropriate for older people with mental health conditions. Residents attend activities in other units as appropriate. There are resources available for care staff to use for one-on-one time with the resident. Staff could describe a low stimulus environment.</p> <p>Relatives stated they were satisfied with the activities provided and that staff were involved in activities with their loved ones, even if only passive participation.</p> <p>An activity profile and 'Map of Life' is completed on admission in consultation with the resident/family (as appropriate). Activity plans sighted in eight of nine files (one file was very new admission and one was for a resident on respite care), were reviewed six monthly at the same time as the care plans. Activity participation sheets were maintained in files sampled. Families are invited to resident meetings. The service also receives feedback and suggestions for the programmes through surveys and one-on-one feedback from residents (as appropriate) and families.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>An RN evaluated all initial care plans (sampled) within three weeks of admission. Long-term care plans have been reviewed at least six monthly in seven of nine files sampled (one file was on respite and another was a new admission) or earlier for any health changes. The multidisciplinary team (MDT) including the GP, are involved in the care plan reviews – on interview the GP confirmed involvement. The GP/NP reviews the residents at least three monthly or earlier if required. The psychiatrist reviews the psychotropic medications for the mental health and psychogeriatric unit residents. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the nine resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to mental health services for the older person, physiotherapist, hospital specialists, wound nurse, nurse practitioner, ophthalmology clinic, podiatrist and dietitian. The service liaises closely with the needs assessment team, geriatrician, psychogeriatric and mental health team. There was evidence of where a resident's conditions had changed and the resident reassessed.</p>

facilitated, or provided to meet consumer choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety datasheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in locked areas. Personal protective clothing is available for staff and was seen to be worn by staff when carrying out their duties during the audit. Blood and chemical spills kit are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires on 16 March 2017. A maintenance/gardener staff member works 30 hours per week and is available on call for facility matters. Planned and reactive maintenance systems are in place. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures have been tested and recorded fortnightly with corrective actions for temperatures outside of the acceptable range.</p> <p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas and secure outdoor areas in the secure units. There is outdoor seating and shade.</p> <p>Staff stated they have all the equipment required to provide the level of care documented in the care plans.</p> <p>The psychogeriatric unit and mental health units have large lounges and dining areas with a separate quiet area. There are external areas with seating where quieter activities or family visits can take place. There are quiet, low stimulus areas that provide privacy when required. For safety reasons, staff control access to the bedrooms and garden areas in the mental health unit.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	FA	<p>Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are both shared ensuites and communal use bathrooms/toilets in the hospital. There are communal toilets and showers in the psychogeriatric unit and mental health units. There are communal toilets located near the lounge/dining rooms. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p>

facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There are both single and dual occupancy rooms. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalize their rooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas within the facility include an open plan lounge and dining area in the hospital plus several smaller lounges. The psychogeriatric and mental health units each have a large lounge with staff present at all times and a separate dining area. There are smaller lounges and a family room within the facility. The communal areas are easily accessible for residents. Seating and space is arranged to allow both individual and group activities to occur.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There is dedicated housekeeping staff seven days a week. Cleaning trolleys are kept in designated locked cupboards. Laundry is completed by a service external to Parkhaven that services several aged care homes, on the Parkhaven site. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely	FA	Emergency and disaster policies and procedures are in place. An approved fire evacuation plan is available. Fire evacuation drills take place every six months. The orientation programme and annual education and training programme include mandatory fire and security training. Staff interviewed confirmed their understanding of emergency procedures. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency.

response during emergency and security situations.		<p>A call bell system is in use. Residents were observed in their rooms with their call bell alarms in close proximity. A minimum of one person is available 24 hours a day, seven days a week, with a current first aid/CPR certificate.</p> <p>External lighting and security systems are adequate for safety and security.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Bupa has an established infection control (IC) programme implemented at Parkhaven. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. The clinical manager is the designated infection control nurse with support from the registered nurses and other Bupa infection control coordinators. The IC team meets as part of the quality team meeting to review infection control matters. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Parkhaven. The infection control (IC) nurse has maintained his practice by completing online infection control updates. The infection control team (the quality team) is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff.</p>

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		The policies are reviewed and updated at least annually.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The facility is committed to the ongoing education of staff and residents. The infection control coordinator, who has completed training to ensure knowledge of current practice, facilitates education. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information is provided to residents and visitors that is appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2016.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	PA Low	The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections, except urinary tract infections (UTIs) in the hospital. Infections (except hospital UTIs) are included on a monthly register and the infection control coordinator completes a monthly report. Infection control data is collated monthly and reported at the quality meetings. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP and nurse practitioner who advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. An influenza outbreak in July and August 2015 was well managed.
Standard 2.1.1: Restraint minimisation Services demonstrate that the	FA	Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. The service has documented systems in place to ensure the use of restraint is actively minimised. There

<p>use of restraint is actively minimised.</p>		<p>were twelve residents with an approved restraint (bed rails, lap belt, and low bed) and nine residents with an enabler (lap belts, bedrails). All required documentation has been completed in relation to enabler use under the restraint minimisation standard, evidenced on one resident file selected for review. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. The roles and responsibilities for the designated restraint coordinator (RN) and for staff are documented and understood, evidenced in interviews with the restraint coordinator and care staff. The restraint approval form identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Either an RN or the restraint coordinator/RN undertakes assessments in partnership with the resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Two hospital-level residents' files were reviewed where restraint was in use (lap belts and bed rails). Ongoing consultation with the resident and family/whānau were evident. Completed assessments considered those listed in in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Low</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints include bed rails, lap belts and low beds. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator. The use of restraint is linked to the residents' care plans. Internal audits measure staff compliance in following restraint procedures. Each episode of restraint is scheduled to be monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is supposed to be</p>

		<p>documented on a specific restraint monitoring form and was evidenced in two residents' files for the use of bedrails but not for the use of lap belts. When residents are taken into the lounge with a lap belt on, restraint monitoring is visual but is not being documented.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the ongoing reassessment of residents on the restraint register, and as part of the care plan review. Families are invited to be included as part of this review. A review of two files of residents using restraints identified that evaluations were up-to-date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Restraints are discussed and reviewed at the six-monthly Bupa teleconference restraint meetings, which is attended by the restraint coordinators from the Bupa aged care facilities. Meeting minutes include (but are not limited to) a review of the restraint and challenging behaviour education and training programme for staff and review of the organisation's restraint policies and procedures.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>A comprehensive education and training programme is in place for staff that includes in-service training, competency questionnaires and toolbox talks. In-services are repeated to improve attendance rates.</p> <p>Two out of 10 staff files reviewed reflected overdue annual performance appraisals. The care home manager confirmed there are a few staff that have not had a performance appraisal completed in the past year.</p> <p>Sixteen caregiver staff are rostered to work in the garden wing (PG unit and</p>	<p>(i) Two out of 10 staff files reviewed reflected overdue annual performance appraisals.</p> <p>(ii) Three of sixteen staff who have been employed for over one year and work in the garden wing (psychogeriatric and mental health) have not completed the</p>	<p>i) Ensure that all staff undergoes annual performance appraisals.</p> <p>ii) Ensure that all staff who have been employed for over one year complete the required dementia standards before they are</p>

		MH unit). One of sixteen caregiver staff has been employed for less than one year and is enrolled and working on completing her dementia standards. Three of sixteen staff who have been employed for over one year have not completed the required dementia standards.	required dementia standards.	rostered to work in the psychogeriatric unit. 90 days
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>One registered nurse is rostered 24/7 to work in the garden wing (PG and MH residents live in two separate, distinct areas with a shared staff office). Hospital level staffing alternates between an enrolled nurse and a registered nurse on the night and weekend shifts. Adequate numbers of caregivers are rostered throughout the facility.</p> <p>Six activities staff (5.8 full time equivalents) are employed to provide activities for residents Monday-Friday in the hospital, PG and MH units and for the day programme clients. Caregivers are not rostered for the day care programme although the communal area for the hospital wings is shared with day programme clients. Caregivers interviewed confirmed that their assistance with the day programme is not required.</p> <p>Extra staff can be called on for increased resident requirements.</p> <p>Interviews with staff, residents and family members identified that</p>	The staffing rationale for the hospital has an enrolled nurse working on weekends and during the night shift with no other registered nursing support in the hospital.	<p>Ensure the hospital wings are staffed with a registered nurse 24 hours a day, seven days a week.</p> <p>30 days</p>

		staffing is adequate to meet the needs of residents.		
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	PA Low	<p>Medication charts sampled in the hospital wing all have appropriate medication prescribing documented. 'As required' medications prescribed in the mental health and psychogeriatric wings by the psychiatrist did not all have indications for use documented. Previous charts (current until 2 May 2015) sighted, had indications for use hand written for these medications and this had not been included on the pharmacy generated charts that were reprinted and became current on 3 May 2016.</p>	<p>Five of eight medication charts sampled in the psychogeriatric and mental health units did not have 'indications for use' documented for 'as required' medications.</p>	<p>Ensure indications for use are documented for all 'as required' medications.</p> <p>60 days</p>
<p>Criterion 1.3.5.4</p> <p>The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/ whānau if appropriate.</p>	PA Low	<p>One of two files sampled (for a new admission) had recent documentation from the DHB that clearly documented early warning signs and triggers and prevention of these for the resident.</p>	<p>One of two files sampled in the mental health unit did not have early warning signs or relapse-prevention plans documented.</p>	<p>Ensure that all residents in the mental health unit have early warning signs and relapse-prevention plans documented.</p> <p>90 days</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction</p>	PA Low	<p>Infections included in surveillance (and benchmarking) data are determined by the Bupa standardised</p>	<p>UTIs in the hospital have not been included in</p>	<p>Ensure all infections are included in</p>

<p>and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>		<p>definitions. Confusion around the interpretation of the definition of UTIs by the clinical manager and hospital coordinator means no UTIs in the hospital were included in the infection-control surveillance data for the past 18 months. Review of medical notes and laboratory records confirmed that UTIs have occurred.</p>	<p>the infection-control surveillance data for the past 18 months. (However, management of individual UTIs have occurred and therefore this criterion has been rated as low risk).</p>	<p>infection-control surveillance data.</p> <p>90 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>	<p>PA Low</p>	<p>Two resident files were selected for review. Both residents were using bedrails and lap belts as restraints. Monitoring forms are retained in each resident's room. Documented evidence of two-hourly monitoring while bedrails were in place, was evidenced for both residents. Missing was documented evidence of monitoring while lap belts were used as restraint. The restraint coordinator remarked that this is because the resident is taken to the lounge when using a lap belt, where staff are present and visually monitor residents.</p>	<p>When lap belts are in situ, residents are in a communal area and staff monitor the residents visually but this is not being documented on a restraint monitoring form. Monitoring forms were completed for the residents' two-hourly checks in their rooms when bedrails were in place.</p>	<p>Ensure lap belts, when used as a restraint, are monitored with evidence of monitoring documented on the appropriate form.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.